DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 0 0 0 9

2. STATE: GEORGIA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 2000

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☐ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.203(b)

7. FEDERAL BUDGET IMPACT:
a. FFY 2000 $ 4,057,690
b. FFY 2001 $ 12,173,071

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
ATTACHMENT 4.19-B Page 1c

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
ATTACHMENT 4.19-B Page 1c

10. SUBJECT OF AMENDMENT:
METHODOLOGY FOR SETTING PAYMENT RATES FOR DENTAL PROCEDURES PROGRAM

GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED:

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gary B. Redding

14. TITLE:
Director, Division of Medical Assistance

15. DATE SUBMITTED:
9/29/2000

16. RETURN TO:
Georgia Department of Community Health
Division of Medical Assistance
2 Peachtree Street, N.W.
Atlanta, Georgia 30303-3159

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
September 29, 2000

18. DATE APPROVED:
March 15, 2001

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 2000

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
Eugene A. Crosser

22. TITLE:
Associate Regional Administrator
Division of Medicaid and State Operations

23. REMARKS:

FORM HCFA-179 (07-92)

Instructions on Back

POLICY AND METHODS FOR ESTABLISHING PAYMENT RATES FOR OTHER TYPES OF CARE OR SERVICES

c. Dental Services

Payments are ,made for specific authorized procedures on a statewide basis and are limited to the lower of:

(1)` The dentist's actual charge for the service; or

(2) The statewide reimbursement rate in effect on the date of services.

Reimbursement will be made on a per procedure basis.

Reimbursement to providers of dental services is made on an established fee schedule not to exceed prevailing charges in the state.

Reimbursement will be provided on a per procedure basis. The current reimbursement rates will be based on a percentage of usual and customary reimbursement, not to exceed 100 percent. The usual and customary reimbursement will be determined using regional data on a periodic basis.